VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 3, 2012

Ms. Meagan Buckley, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Provider #: 475020

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **February 29, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. BUILDING _____ B. WING _____	C 02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN HEALTH & REHAB CTR	98 HOSPITALITY DRIVE BARRE, VT 05641

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F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 2/29/12. The following are the regulatory violations identified.	F 000		
F 201 SS=G	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced	F 201	1. Resident #1 no longer resides at the center. 2. All residents with a discharge plan have the potential to be affected by this alleged deficient practice. 3. Any resident who is unable or unwilling to transfer at time of discharge will be evaluated by the unit manager or designee. The therapy department will evaluate the resident if needed. 4. Reeducation of the unit managers and nurses will be completed to include evaluation of the resident prior to discharge or when a significant change in	F201 POC corrected

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

L. Cummings RN

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

fme

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F 201	Continued From page 1 by: Based upon interview and record review, the facility failed to ensure that a discharge was appropriate because the resident's health improved sufficiently so the resident no longer needed services provided by the facility for one applicable resident. (Resident #1). Findings include: Per record review and confirmed with the Director of Nursing (DNS) on 2/29/12 at 2:03 PM, the 2/3/12 the Admission Nursing Evaluation for Resident #1 states: "Mobility: Ambulates with assist of one, Comments: Ambulates with a walker device and one assist". The 2/21/12 Nursing Discharge Note states, "Discharged today home with his son and home health services. Resident did not participate in transfers from bed to wheelchair or wheelchair to car. Very drowsy, non responsive. PT [Physical Therapy] informed." In addition, the DNS confirmed that the MD (physician) was not informed of the resident's condition at time of discharge. Per staff interview with a Licensed Practical Nurse (LPN) on 2/29/12 at 2:45 PM (with the DNS present during the interview), Resident #1 was discharged on 2/21/12 at 11:00 AM. Prior to exiting the building, s/he stated that Resident #1 was very drowsy. The LPN and LNA (Licensed Nursing Assistant) had to "pick him up to move him from the bed to the wheelchair". The LPN stated s/he informed the Unit Manager that the resident was very drowsy and not responding to commands. The LPN was directed to proceed with the discharge. The LPN and LNA transported the resident to the car via wheelchair and the resident was unable to assist them in	F 201	mobility is noted. 5. Random weekly audits to be completed by DNS or designee to measure effectiveness of plan start by 3/29/12. 6. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 7. Corrective action shall be complete by 3/29/12. F 201 POC accepted T. Cummings RN	

Fax 8022412348 Mar 14 2012 03:07pm P007/016
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F 201	Continued From page 2 transferring from the wheelchair to the car. The LPN notified the Unit Manager a second time and was told to contact Physical Therapy concerning how they transfer the resident. The LNA picked up the resident and pivoted him/her into the car. The resident's son stated he did not know how he was going to transfer the resident from the car to the house. After returning to the facility, the LPN informed the Unit Manager that s/he did not think that Resident #1 should have been discharged. Per record review of documents obtained from Central Vermont Medical Center, the 2/21/12 Emergency Department Physician Summary states: "Diagnosis Primary: Dehydration; Patient Status: Patient status is critical; Chief Complaint: The caregiver found [Resident #1] half off the chair and unresponsive so called EMS [Emergency Medical Services]; Severity: Maximum severity is severe, currently symptoms are severe". Per record review of the 2/21/12 Emergency Department Physician Summary History and Physical, Resident #1's, "Chief Complaint: unresponsive"; Clinical Impression: significant volume depletion and sodium is markedly elevated at 156"; Disposition: [Resident #1] will be admitted to the ICU [Intensive Care Unit] as a full admission". Also see F281	F 201	F 201 POC accepted T. Cumming RN	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281	F281 POC accepted T. Cumming RN	

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F 281	Continued From page 3 by: Based upon interview and record review, staff failed to meet professional standards of quality for 1 applicable resident by: 1) Failing to notify the Physician concerning a low blood pressure reading; 2) Failing to notify the Physician that the Resident was very drowsy and unresponsive at the time of discharge; and 3) Not monitoring the Resident's intake and output when indicated. (Resident #1) In addition, Resident #1 required an admission to an Intensive Care Unit at a local hospital the same day as discharge from the facility for dehydration. Findings include: Per record review of the Physician Orders, Nursing Notes and documentation of blood pressure readings for Resident #1, and confirmed with the Director of Nursing (DNS) on 2/29/12 at 1:27 PM, the Resident's Blood Pressure (BP) was documented as 88/48 on 2/18/12. Staff did not report the low BP to the Physician (MD) and did not assess Resident #1 per Facility policy "Blood Pressure, Measuring" for low blood pressure readings. Per review of the Facility policy, "Blood Pressure, Measuring": Hypotension is defined as blood pressure less than 100/60 mm/hg. The policy states that hypotension should be reported to the physician and that staff should record several readings throughout the day, including before and after meals. Per record review and confirmed with the DNS on 2/29/12 at 1:27 PM, there is no documentation of additional BP readings per Facility Policy for Resident #1 and the 2/18/12 nursing note states Resident #1 is oriented to name and unable to follow simple commands. Per record review and confirmed with the Director	F 281	1. Resident #1 no longer resides at the center 2. Any blood pressure indicative of hypotension will be reported to the physician as per policy. 3. Any significant change in transfer ability and/ or unresponsiveness will be reported to the physician. 4. All residents will have dietician assessment for fluid/meal requirements. Deviations from the fluid requirement below 1200cc/24 hours will be reported to the unit managers or designee for follow up with the physician and the dietician if necessary. 5. Nurses will be reeducated regarding F 281 POC amended T. Cummings RN	

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F 281	Continued From page 4 of Nursing (DNS) on 2/29/12 at 2:03 PM, the 2/3/12 the Admission Nursing Evaluation for Resident #1 states: "Mobility: Ambulates with assist of one; Comments: Ambulates with a walker device and one assist". The 2/21/12 Nursing Discharge Note states, "Discharged today home with his son and home health services. Resident did not participate in transfers from bed to wheelchair or wheelchair to car. Very drowsy, non responsive. PT [Physical Therapy] informed." In addition, the DNS confirmed that the MD (physician) was not informed of the resident's condition at time of discharge. Per staff interview with a Licensed Practical Nurse (LPN) on 2/29/12 2:45 PM (with Director of Nursing present during the interview), the resident was discharged on 2/21/12 at 11:00 AM. Prior to exiting the building, s/he stated the resident was very drowsy. The LPN and LNA (Licensed Nursing Assistant) had to "pick him up to move him from the bed to the wheelchair". The LPN stated s/he informed the Unit Manager that the resident was very drowsy and not responding to commands. The LPN was directed to proceed with the discharge. The LPN and LNA transported the resident to the car via wheelchair and the resident was unable to assist them in transferring from the wheelchair to the car. The LPN notified the Unit Manager a second time and was told to contact Physical Therapy concerning how they transfer the resident. The LNA picked up the resident and pivoted him/her in the car. The resident's son stated he did not know how he was going to transfer the resident from the car to the house. When the LPN returned to the facility, s/he told the Unit Manager that s/he did not think the resident should have	F 281	the policy for blood pressures, I&O requirements, and procedure to be followed when a resident is non-responsive or experiences a significant change in transfer status. 6. Random weekly audits to be completed by DNS or designee to measure effectiveness of plan start by 3/29/12. 7. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 8. Corrective action shall be complete by 3/29/12. F 281 POC accepted T Cummings	

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F 281	Continued From page 5 been discharged. Per record review and confirmed during interview with the Director of Nursing (DNS) on 2/29/12 at 1:10 PM, Resident #1 was not on Intake and Output monitoring. Per facility policy "Resident Hydration and Prevention of Dehydration, "The dietician will assess all residents for hydration adequacy at least quarterly and more often as necessary per resident need. Minimum fluid needs will be calculated and documented on initial assessment, nursing will assess for signs and symptoms of dehydration during physical care, and if potential inadequate intake and/or signs of symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan, the dietician, nursing staff and the physician will assess factors that may be contributing to inadequate fluid intake. Per record review of the 2/14/12 nursing notes and confirmed with the DNS on 2/29/12, the resident had 3 loose stools on 2/14/12 and Norovirus (gastrointestinal illness) was present in the facility on this date. Per record review of the 'Follow Up Question Report: What percentage of the meal was eaten' for Resident #1 and confirmed with the Registered Dietician on 2/29/12 at 11:38 AM, from 2/3/12 to 2/10/12 (ending at 1:39 PM), Resident #1 consumed 19 meals. At 12 of those 19 meals, the resident consumed less than 50% of the meal. From 2/10/12 (starting at 2:40 PM) to 2/21/12, the resident consumed 33 meals. The resident refused 7 of 33 meals, and for 23 of 33 meals, the resident consumed less than 50% of the meal.	F 281	F 281 POC accepted T. Cummings RN	

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F 281	Continued From page 6 Per record review of documents obtained from Central Vermont Medical Center, the 2/21/12 Emergency Department Physician Summary states: "Diagnosis Primary: Dehydration, Patient Status: Patient status is critical; Chief Complaint: The caregiver found [Resident #1] half off the chair and unresponsive so called EMS ... [Emergency Medical Services]; Severity: Maximum severity is severe, currently symptoms are severe". Per record review of the 2/21/12 Emergency Department Physician Summary History and Physical, Resident #1's, "Chief Complaint: unresponsive"; Clinical Impression: significant volume depletion and sodium is markedly elevated at 156"; Disposition: [Resident #1] will be admitted to the ICU [Intensive Care Unit] as a full admission". Also see F201 and 327.	F 281	F 281 POC accepted T. Cummings RN	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to provide the necessary care and services to attain or maintain the highest	F 309	1. Resident #1 no longer resides in the center. 2. Any resident with hearing impairment or lack of a hearing device have the potential to be affected by this alleged deficient practice. 3. The care plans of all residents' will be	F309 POC accepted T. Cummings RN

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F 309	Continued From page 7 practicable physical, mental, and psychological well-being for one applicable resident by not developing an Interim Plan of Care related to a communication deficit. (Resident #1). Finding includes: Per interview with Director of Nursing (DNS) and confirmed on 2/29/12 at 3:04 PM, there was no interim care plan related to Resident #1's communication deficit which included deafness and loss of hearing aid. In addition, the DNS confirmed on 2/29/12 at 2:10 PM that the Admission Nursing Assessment dated 2/3/12 documented the resident has profound deafness. Per record review of the 2/22/12 Social Service Note and confirmed during interview with the Social Worker on 2/29/12 at 2:34 PM, Resident #1 is hard of hearing and left hearing aid was lost at Central Vermont Medical Center (CVMC). During the interview, the Social worker stated the hearing aid was missing upon admission to the facility and it was challenging for staff to work with the resident since s/he did not have a hearing aid.	F 309	audited to ensure that if a hearing impairment is a problem, the impairment is noted on the care plan. 4. Nurses will be reeducated to include hearing impairment on the resident care plan. 5. Random weekly audits to be completed by DNS or designee to measure effectiveness of plan start by 3/29/12. 6. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 7. Corrective action shall be complete by 3/29/12.	F309 POC reviewed T. Cummings RN
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	~~F 325~~		

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F 309	Continued From page 7 practicable physical, mental, and psychological well-being for one applicable resident by not developing an Interim Plan of Care related to a communication deficit. (Resident #1). Finding includes: Per interview with Director of Nursing (DNS) and confirmed on 2/29/12 at 3:04 PM, there was no interim care plan related to Resident #1's communication deficit which included deafness and loss of hearing aid. In addition, the DNS confirmed on 2/29/12 at 2:10 PM that the Admission Nursing Assessment dated 2/3/12 documented the resident has profound deafness. Per record review of the 2/22/12 Social Service Note and confirmed during interview with the Social Worker on 2/29/12 at 2:34 PM, Resident #1 is hard of hearing and left hearing aid was lost at Central Vermont Medical Center (CVMC). During the interview, the Social worker stated the hearing aid was missing upon admission to the facility and it was challenging for staff to work with the resident since s/he did not have a hearing aid.	F 309	F309 POC accepted 1. Cmm 3/14	
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	1. Resident #1 no longer resides in the center. The resident did not experience weight loss during the stay at the center. 2. All residents have the potential to be affected by this alleged deficient practice.	F325 POC accepted 1. Cmm 3/14

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F 325	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to complete a Nutritional Assessment for one applicable resident which includes the estimated needs for calories and fluids upon admission and prior to discharge (Resident #1). Findings include: Per record review of the Registered Dieticians Progress Note and Nutritional Assessment dated 2/9/12 and confirmed with the Registered Dietician (RD) on 2/29/12 at 11:38 AM, Resident #1's nutritional assessment was incomplete and did not include the estimated nutrient needs for calories or fluids. Per interview on 2/29/12 at 12:05 the RD calculated, per request of the surveyor, that Resident #1's daily fluid requirement is 1648 cc fluid per day based upon a height of 69 inches and recorded weight of 145 pounds. Per record review and confirmed with the Registered Dietician (RD) on 2/29/12 at 11:38 AM, the 'Follow Up Question Report: What percentage of the meal was eaten', Resident #1 consumed 19 meals from 2/3/12 to 2/19/12 (ending at 1:39 PM). At 12 of those 19 meals, the resident consumed less than 50% of the meal. From 2/10/12 (starting at 2:40 PM) to 2/21/12, the resident consumed 33 meals. The resident refused 7 of 33 meals, and for 23 of 33 meals, the resident consumed less than 50% of the meal. In addition, the 2/9/12 RD Progress Note for Resident #1 states "Nutrition assessment: PO (oral) intake overall fair with approximately 2/3 of	F 325	3. All resident's records will be audited for a complete dietician assessment including estimated nutrient needs for calories and fluid. The dietician will continue to recommend supplements based on her assessment of needs. 4. Dietician will be reeducated on facility policy for completing dietician assessments. 5. Random weekly audits to be completed by Regional RD or designee to measure effectiveness of plan start by 3/29/12. 6. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time.	F 325 POC accepted 1 Cmm RN

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F 325	Continued From page 9 meals at 25%; Decreased appetite prior to admission noted, expected to improve as as resident adjusts/recovers". Also, the RD stated that at the 2/16/12 Weight Meeting, food refusal for all residents was noted and discussed at the interdisciplinary meeting and no dietary supplements were ordered for Resident #1. Also see F327	F 325	7. Corrective action shall be complete by 3/29/12. F325 POC received T Cumings RN	
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to assure that 1 applicable resident received sufficient amount of fluids based upon individual needs, who then required admission to an Intensive Care Unit at a local hospital the same day as discharge from the facility for dehydration. (Resident #1). Findings include; Per Policy Review "Resident Hydration and Prevention of Dehydration" and confirmed during interview with the Director of Nursing (DNS) on 2/29/12 at 1:10 PM, the policy states the dietician will assess all residents for hydration adequacy at least quarterly and more often as necessary per resident need. Minimum fluid needs will be calculated and documented on initial assessment, nursing will assess for signs and symptoms of dehydration during physical care,	F 327	1. Resident #1 no longer resides in the center. Resident did not experience weight loss during the stay at the center. 2. All residents with decreased fluid intake due to a change in condition have the potential to be affected by this alleged deficient practice. 3. Minimum fluid intake will be determined by the dietician as per the assessment. F327 POC received T Cumings RN	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. BUILDING _____ B. WING _____	C 02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 327	Continued From page 10 and if potential inadequate intake and/or signs of symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan, the dietician, nursing staff and the physician will assess factors that may be contributing to inadequate fluid intake. Per record review of the Registered Dieticians Nutritional Assessment dated 2/9/12 and confirmed with the Registered Dietician (RD) on 2/29/12 at 11:38 AM, Resident #1's nutritional assessment was incomplete and did not include the estimated nutrient needs for calories or fluids. During the interview, the RD stated s/he did not update the nutritional assessment upon admission and prior to discharge. The RD stated that Resident #1's food and fluid requirements were not calculated during the resident's stay. Per interview on 2/29/12 at 12:05 PM the RD calculated, per request of the surveyor, that Resident #1's daily fluid requirement is 1648 cc fluid per day based upon a height of 69 inches and recorded weight of 145 pounds. Per record review of the nursing notes and confirmed with the DNS on 2/29/12, Resident #1 had 3 loose stools on 2/14/12 and Norovirus (gastrointestinal illness) was present in the facility on this date. Per record review and confirmed with the Registered Dietician (RD) on 2/29/12 at 11:38 AM, the 'Follow Up Question Report: What percentage of the meal was eaten', Resident #1 consumed 19 meals from 2/3/12 to 2/19/12 (ending at 1:39 PM). At 12 of those 19 meals, the resident consumed less than 50% of the meal.	F 327	4. All resident nutritional assessments will be audited to ensure completion of nutrition and fluid intake requirements. 5. Intake documentation will be initiated as per center policy and procedure. 6. Residents on intake monitoring will be evaluated for dehydration if the minimum fluid intake is not maintained for 3 days and the residents has a condition where fluid loss is anticipated. 7. Supplements will continue to be recommended as per the dietician assessment of nutritional needs. 8. Nurses will be reeducated on the policy and procedure for Intake implementation,	F327 POC accepted T. Cumps RN

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F 327	Continued From page 11 From 2/10/12 (starting at 2:40 PM) to 2/21/12, the resident consumed 33 meals. The resident refused 7 of 33 meals, and for 23 of 33 meals, the resident consumed less than 50% of the meal. In addition, the 2/9/12 RD Progress Note for Resident #1 states "Nutrition assessment: PO (oral) intake overall fair with approximately 2/3 of meals at 25%; Decreased appetite prior to admission noted, expected to improve as as resident adjusts/recovers". Also, the RD stated that at the 2/16/12 Weight Meeting, food refusal for all residents was noted and discussed at the interdisciplinary meeting and no dietary supplements were ordered for Resident #1. Per record review of documents obtained from Central Vermont Medical Center, the 2/21/12 Emergency Department Physician Summary states: "Diagnosis Primary: Dehydration; Patient Status: Patient status is critical; Chief Complaint: The caregiver found [Resident #1] half off the chair and unresponsive so called EMS [Emergency Medical Services]; Severity: Maximum severity is severe, currently symptoms are severe". Per record review of the 2/21/12 Emergency Department Physician Summary History and Physical, Resident #1's, "Chief Complaint: unresponsive"; Clinical Impression: significant volume depletion and sodium is markedly elevated at 156"; Disposition: [Resident #1] will be admitted to the ICU [Intensive Care Unit] as a full admission".	F 327	dehydration evaluation and documentation. 9. Random weekly audits to be completed by DNS or designee to measure effectiveness of plan start by 3/29/12. 10. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time. 11. Corrective action shall be complete by 3/29/12.	

F327 POC corrected 1. Cumbs RN